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BULLETIN of the
MENNINGER CLINIC

VOLUME 10 NOVEMBER, 1946 NUMBER 6

PSYCHIATRY IN FRANCE*

By PIERRE D. FOUQUET, M.D.†

A brief historical review of French psychiatry may be helpful in understanding the present situation of psychiatry in France. We can say that the evolution of French psychiatry and American psychiatry has been roughly the same; I mean that they have moved in a parallel direction. I was particularly impressed by the fact that both the American Psychiatric Association and the Medical Psychological Society of France were founded at the same time and that each published at the same time, a hundred years later, a special book commemorating one hundred years of psychiatry. I believe, however, that the American effort is definitely ahead of the French at this time.

I

After the spectacular and emancipating action of Pinel in the beginning of the 19th century a number of French psychiatrists attacked the problem of mental illness. Their efforts resulted in the passing of a law in 1838 on the treatment of mental illness, which was the first social welfare law of France. This law was not inspired merely by the fear of the so-called lunatic, but also by the concept that people who are mentally ill deserve treatment. Surprisingly, provisions were included for the commitment and the discharge of the patient, which constituted a revolutionary step, since the principle of French law has always been to guard individual freedom. For the first time, because of the concept of disease, a mentally ill person could be deprived of freedom, both physically and legally. It was already understood that he had to be treated and at the same time that his personal property was to be safeguarded. This law made it

* Presented at a Staff Seminar at the Menninger Foundation May 22, 1946.

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compulsory for each French department, which is roughly equivalent to a state in America, to establish an institution for the care and treatment of mentally ill patients.

The main work of French psychiatrists up to the end of the 19th century was the description and classification of the different states of "insanity," and I believe that their descriptions are still good today. Esquirol, for instance, described the principal types of psychoses as we know them today. As early as 1822 Bayle in Charenton had described for the first time general paresis and wrote his thesis on meningo-encephalitis. Morel in the middle of the 19th century was the first to describe a type of dementia in young people and he named it dementia praecox. Up to Magnan, French psychiatrists kept trying to define and isolate mental diseases in parallel with somatic diseases, under the influence of the general concept of general paresis. Because of Bayle's general paresis description showing that one type of mental illness was due to a specific organic disease French psychiatrists were led to believe that sooner or later all mental illnesses would surely show a physical etiology as well. Charcot at the end of the 19th century studied neuroses, but he was also a neurologist and organicist. The portion of his work concerning neuroses was violently attacked by the neurologists who followed. For instance Babinski, when he first described his sign, insisted that this was objective, that we could build on such objective material a scientific neurology, and that the rest was more or less metaphysics, more or less mythical.

Before Charcot several French authors, such as Itard, Seguin, and Bourneville had already established the first principles of child psychiatry.

II

At the beginning of the 20th century French psychiatry began to decline. Among the reasons for this decline were the discoveries of Pasteur, the development of bacteriology and other laboratory techniques, and the birth of modern surgery with emphasis on physical medicine—physicians believed then that medicine was becoming an exact science. Many young physicians were attracted by this promise. In the country of Descartes the relation between the physical and the mental was considered from the viewpoint of dualism. Psychology itself became a laboratory and esoteric science which claimed to make precise measurements. An important portion of psychology lost touch with humanity. For these reasons and others a public interest in mental diseases and human mental processes in general began to wane. As a result French psychiatry shut itself into the lunatic asylums, which were generally built away from cities and isolated from normal social life, and concentrated on the committed patients.

III

Yet in that same period, I mean the beginning of the 20th century, there were in France some psychiatrists and psychologists who studied the problem as a whole and built a dynamic work which even now retains a certain value and appears definitely modern. For example, the important work of Pierre Janet was published in the first quarter of the 20th century. Let us recall that the first I.Q. tests were established and formulated in France by Binet, a French psychologist, and Simon, a French psychiatrist. In that same period Toulouse, a French psychiatrist, established the first basis of mental hygiene in Europe and at the same time that Clifford Beers was establishing a Committee for Mental Hygiene in the United States, Toulouse in France was establishing a league for mental hygiene and creating hospitals for voluntary patients. In spite of these few workers that I have just mentioned, however, French psychiatry was on the decline and German psychiatry was leading; for instance, Kraepelin with his synthesis of dementia praecox, Bleuler with his concept of schizophrenia and finally Freud.

IV

Let us consider now the situation of psychiatry in France following World War I. The final expression of somatic, mechanistic, atomistic, nosologic psychiatry was formulated by De Clerambault. Since 1925 new doctrinal tendencies have appeared in French psychiatry, particularly the works of Henri Ey who applied to psychiatry the dynamic principles of Jackson as he used them in neurology. He has not completed his work but he is having a very strong influence on French psychiatry because he has in the last 15 years trained perhaps 30 percent of the young French psychiatrists. His doctrine is organo-dynamic and monistic. He claims that mental diseases do not exist as entities and that all the different states of psychosis represent different levels of mental dissolution, and regression; in every state of mental disturbance, even in the slightest, he considers that there is a positive part and a negative part, the positive part being that which persists and the negative part being that which has been destroyed. The patient has to reorganize his mode of living, his social relationships, his personal being and his somatic being. This school has already produced a certain amount of work, the tendencies of which are fairly close to those of American psychiatry.

In child psychiatry the school of Heuyer has made progress in its efforts to have this problem recognized as an essentially medical and social one. However, the principal tendency of French psychiatry is to remain essentially somatic: in experimental research, body structure and measure-

ments, pathological anatomy, biological research, endocrinology, etc. For example, the hypothesis on the part played by the mesencephalon in the etiology of mental diseases: biological research on the post-electric shock syndrome which tend to prove that the mesencephalon is principally involved, and encephalography, are done at the Sainte-Anne hospital in Paris, under Professor Delay. Therapeutics, such as malaria therapy, insulin therapy, shock therapy, narcotherapy and the applications of neurosurgery are essentially the same as in the United States. The research work concerning psychotherapy and social psychiatry are definitely far behind the developments we see in America. Psychoanalysis has been relatively slow in penetrating psychiatric circles in France.

At the present time and as a whole the problems confronting French psychiatry are essentially the same as here in America.

(a) The elaboration and construction concerning the essence of psychiatry, its real meaning; in other words, what is psychiatry and what should its role be in our modern social life?

(b) The education of psychiatrists, under-graduate and post-graduate training, and the orientation of general practitioners, nurses, social workers and the general public. Let me put in a parenthetical statement to give you a few facts about the training of medical students in France.

The study of medicine requires six years, preceded by one year of preparatory biology, physics and chemistry. The student must also have an A.B. or B.S. degree before he can enter a medical school. The clinical teaching is given every morning in hospitals, and practical work such as dissection, laboratory techniques, etc. and also lectures by professors, are given in the afternoon at the medical school. The best students have the opportunity to enter a special contest, usually during their fourth year. If they succeed they become "interns" in teaching hospitals for four years. This title is misleading and corresponds to "resident" in the United States. At the end of the 4th or 5th year the students have generally decided whether they will practice general medicine or a specialty.

The students who do not pass this special test (which is not compulsory) must then spend one year in a hospital. This corresponds to the American internship with the difference that, since, during the five preceding years, they have already spent every morning in hospitals, rotating to cover all the branches of medicine and surgery, they are allowed to choose, for the 6th year, the field they are particularly interested in. Finally, the student must present a thesis which is a personal, original work on a subject selected by the student. This thesis, which is generally from 50 to 100 pages, is printed. The student discusses this thesis in a public examination conducted by three professors. When this thesis is accepted, the student is then given his M.D. degree. This degree gives him automatically a

license to practice every branch of medicine, obstetrics, and surgery in the whole of France and its possessions.

As for the teaching of psychiatry for undergraduates, it is during the 5th year only that they receive it. It consists of six weeks of hospital attendance with clinical teaching and lectures. The post-graduates who wish to specialize in psychiatry enter a competitive examination to secure residencies in a psychiatric hospital. The usual length of this residency is four years during which they study in more detail anatomy and physiology of the central nervous system and psychiatry. The emphasis, in France, is on the personal clinical work. We have excellent lectures but a great latitude is left to the student in the choice of his personal psychiatric orientation. Few students are psychoanalyzed.

Continental France has 28,000 physicans and there are only 350 psychiatrists for a population of 40,000,000. French speaking psychiatrists meet once a year, in France, Belgium, Switzerland or North Africa. Many foreign psychiatrists attend, representing generally about 40 nations.

The three main psychiatric journals are:

1. *Annales Medico-Psychologiques*—a monthly publication which is 102 years old.

2. *L'Encephale* and its supplement *l'Hygiene Mentale*, also a monthly publication with a somewhat neurologic orientation.

3. *L'Evolution Psychiatrique*—a monthly also with a dynamic and psychoanalytic orientation. We must add *La Revue Francaise de Psychonalyse*. The last three could not be published during the occupation on account of paper shortage. They are now resuming publication.

The text books on psychiatry for undergraduates are relatively meager as there have been no new editions in recent years. But some excellent monographs are published every year on such subjects as psychiatry, psychology, and neurology.

V

After this long parenthesis, let us continue with the problems confronting psychiatry proper.

(c) The application of our present knowledge to practice. I mean the application of our present knowledge to the care of patients in already established psychiatric hospitals and introduction of new principles in establishing new hospitals. I mean also the application of new doctrines in the social welfare plan. For example there are at the present time 624,000 mental patients in the United States hospitals and there is no doubt a considerable gap between the treatment that we know these patients should receive and what they are actually receiving. In the United States the general tendency, which has been realized in a few states only, such as

New York, is to have specialized psychiatric hospitals: mental defective, epileptics, criminally insane, alcoholic, drug addicts, and of course psychoses. Inside these hospitals, the psychiatrists are strictly hierarchized and the fragmentation of work is usually carried very far. For instance, the patient is, on admission, examined by a psychiatrist, a psychologist and an internist. He is then sent to a particular building in the care of a particular psychiatrist who, however, will send him to other psychiatrists for particular treatments such as insulin therapy; he may also be referred to a psychotherapist. The orientation towards huge psychiatric hospitals such as the Pilgrim State Hospital in New York with 9,000 patients, was dictated by economic considerations. But this orientation is now considered poor by most American psychiatrists. In most cases, the patient to be committed must be referred to a special court.

In France there are 97 psychiatric hospitals and they seldom have more than 2,000 beds. They are organized in small units, each having a medical director assisted by residents. Each medical director is responsible and has full authority in his unit. He makes all decisions, diagnoses, transfer, treatment, discharge, etc. In each small unit, all types of patients may be found. The patients are, of course, placed according to their behavior, the disturbed separated from the depressed patients, i.e., the patients at the limit of sociability are segregated in special pavilions. The ideal is to reconstruct a new society, close to real life, without considering the nosologic label. They are housed, not in a big hospital building, but in small treatment units arranged rather like a small town for the resocialization of the patients. This allows the admission of all types of patients, alcoholics, epileptics, mental deficiencies, psychoneurotics, and psychotics. But I repeat that, of course, the idiots and imbeciles or the very severe cases of epilepsy where treatment fails to bring any improvement, must be and are segregated.

The interpersonal relations are studied so that the patients can help one another, which constitutes an indirect and active form of psychotherapy. Work therapy is used and many patients, men and women, work in farms and workshops, either in the hospital or outside. Finally there are "familial colonies," different from the American "family care" in the sense that there are whole villages in which the patients mix with the normal population and work (generally at farming) under psychiatric supervision. In brief, there is no specialization in French psychiatric hospitals, no hierarchy between the medical directors, no fragmentation or dispersion in the relations between the patient and *his* physician. The psychiatrist can, of course, ask for consultation from internists, surgeons, etc. The medical director does not use the psychologist routinely, but there are psychologists who do some research work. Almost every department has a public psychiatric hos-

pital, connected with the Health Center where there is an outpatient service for children and adults. It is also connected with general hospitals. After his discharge the patient is followed up by the social worker. This organization, however, has not yet been realized everywhere, for, like the United States, France suffers from a shortage of trained personnel, psychiatrists, psychiatric nurses and psychiatric social workers. During this war juvenile delinquency has increased markedly and now a special department is coordinating the efforts of the Department of Justice, the Department of Public Health, and the Department of National Education to obtain a better approach to this problem.

In France before this war there were 120,000 mental patients in hospitals and the care they received varied from good to poor according to the hospital. Concerning the protection of the mental health in social life penetration of principles of mental hygiene is still comparatively poor. The relations that psychiatry must establish with related sciences are still considerably underdeveloped in France.

As these tasks confront us, I am glad that I find in both France and the United States the same urge to enact new laws. A proposed bill, now pending in France, covers the same ground as the National Mental Health Act which is before your Senate. There is, however, one essential difference in the French bill which proposes a new mechanism for commitment of voluntary patients.

At the present time the general problem in France is reconstruction. We, the French psychiatrists, want to re-construct French psychiatry so as to insure better protection of mental health, both for the child and the adult. The proof that mental hygiene is a social problem can be found in the fact that during this war juvenile delinquency has increased considerably whereas both psychosis and neurosis have, on the contrary, decreased markedly. The causes of juvenile deliquency are fairly obvious. The family was disrupted, the conditions of life deteriorated, and war and military occupation brought general insecurity. On the other hand, adult people with slight neurotic states, when they are confronted with definite objects of love and definite objects of hate, can find a sort of satisfactory adjustment and it is obvious that the German soldier was an easy object for hatred and the Allied soldier an easy object for love.

While we are waiting for the role that psychiatry will have to play in international relations and for a better order in the world, I am happy to see that the relations between French and American psychiatry are improving, and that five French psychiatrists have come to America, sent by the French government. I hope that in the near future American psychiatrists will be better informed about the condition of French psychiatry and that a mutual exchange of publications will be permanently established

SOME ESSENTIALS IN NATIONAL MENTAL HEALTH PLANNING*

By DANIEL BLAIN, M.D.†

When eight million people‡, constituting six per cent of our nation's total population, are suffering from some form of mental disease or personality disorder, the branch of science devoted to that group of diseases finds itself facing an overwhelming responsibility. And when the six to eight million families of these people are affected by their sick relatives, a large and important portion of the total population is profoundly disturbed. It becomes not only a problem of medical science, but one related to all groups of society.

Accounting for over half of all hospital beds in the civil population, and the larger part of the medical and disability discharges from the armed forces, psychiatric problems are obviously swamping the medical profession. Psychiatry and the medical profession (and I include all specially trained auxiliary groups in the medical profession) are in both an enviable and dangerous position today. Faced with the task of stemming a rising tide, they have a glorious opportunity for national service. If, however, they fail to exert leadership and deal successfully with mental diseases and maladjustment, the prime responsibility will be taken away and will fall into the hands of others.

The problem is of the group rather than the individual. No illnesses are so related to the interplay of an individual and his environment, as those in the mental and emotional field. With this in mind, it is appropriate to speak of national planning—for any plan to eradicate mental and emotional illness is national in scope, in distribution, in size and in importance.

It is well at this point to suggest an orientation toward the problem which I believe is important. Our attention is traditionally focused on the six per cent who are sick. It is the 94% who are well, who are the most important. Planning for mental health must emphasize a positive concept of *health* rather than the negative concept of *disease*.

Planning for Veterans

The Veterans Administration has among its beneficiaries a large portion of the adult male population. Its psychiatric problem is quite similar to that of the nation, in that sixty per cent of its beds are devoted to neu-

* Read at Annual meeting, National Conference of Social Work, Buffalo, N. Y., May 21, 1946.

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‡ Hearings Neuropsychiatric Institute Bill and Social Security Board (private communication).

ropsychiatry, and three out of five claims for disability pensions are neuropsychiatric in origin. Neuropsychiatric hospitals now contain about 50,000 patients. It is estimated that 200,000 beds will be needed by 1975, at which time the peak load should be reached. Estimates of those needing outpatient care are vague, but are based on the 581,000 discharges from the services for mental condition and inaptitude. In a survey just completed in a small eastern state, out of 2600 receiving pensions for psychiatric disorders, over 50% needed outpatient treatment and would have benefited from it, in the opinion of the psychiatrists making the examinations. It is estmated that one hundred thousand need treatment now.

In the last few months efforts have been made in the Neuropsychiatric Division of the Veterans Administration, not only to handle the immediate hospital emergencies, but to lay a broad and solid foundation for effective work over a period of years. Although the Federal Government has by Congressional action fixed the responsibility for 20,000,000 veterans on the Veterans Administration, the very nature of the disease precludes independent planning. The shortage of all facilities indicates a sharing of all assets—just as the general causes operating to produce neurosis are common to all members of the total population. Veterans are a part of the general population. Efforts on our part in care and prevention will be of no avail unless they are matched by similar efforts throughout the country.

We in the Veterans Administration are interested in giving "good medical care" and all that that implies We are now working on improvement of present hospitals as regards more personnel and better equipment; new hospitals with the most up-to-date architectural plans; location in areas near medical schools and associated with them; creation of a chain of mental hygiene clinics adequately staffed with social workers and clinical psychologists; arrangements with all grade A medical schools to start postgraduate training for specialization in psychiatry. We have about 100 residents now and hope to reach 6–800 within a year. Almost all Veterans Administration hospitals and mental hygiene clinics will be made into teaching centers. Money is available for research both of clinical and laboratory type.

In facing a desperate situation filled with emergencies, critical shortages in personnel, we have found great deficiencies in knowledge and very little leadership on which to lean in solving a whole series of major problems. With billions of the people's money going to be spent, it is an awful obligation to see that it is spent wisely. With thousands of our best young men needing immediate definitive treatment, we are impressed with the necessity that methods and techniques shall be right—that these men shall not say years later: "If I had only been treated in time. If I had

only had something better than was offered—I would not be as I am now." So we are asking ourselves many questions. Our suggestions for national planning come in the form of queries. I am not giving the answers. You will see where we are puzzled and looking for help.

(1) What is the real nature and extent of the psychiatric problem of this country? This demands a thorough, comprehensive survey. No effective plan can be devised until the problem is defined, understood and evaluated. Statistics are uncertain, often based on changing nomenclature. The emphasis has been on psychotics, yet the great burden of the load is in the field of the neuroses and maladjustment. The extent of these conditions is almost completely unknown.

What do we know of the extent and nature of mental disease and personality disorder in children, young and aged adults, and the relation of one to the other? Of reactions in various races found in this country? The effects of national strains mixing to form the average American? Have we any comparison of those who are rich, poor and intermediate? The literate as compared to the illiterate? Those of superior and lesser intelligence; the urban and the rural; hot and cold parts of the country; the various groups of employed—farmers, miners, seamen, white collar workers, day laborers, migratory groups, tramps?

Much could be gained by comparing our situation with that in other cultures, studying the effects of fatalism, comparing the incidence and nature of mental disease in countries dominated by various religions such as Buddhist, Mohammedan, Christian. I have been told that there is no mental illness to speak of in the Near East. Is this true, and if so, why? Does the youth or age of a country have a bearing on the precipitation of mental disease? Are we softer and more vulnerable than in pioneer days? Do the enthusiasm and grandiose ideas of those from a pioneer state like Texas, added to superior wealth and natural resources of the state, make Texans more immune to neuroticisms, or less immune?

What about national trends? Do they affect the incidence of nervous breakdown? Are rugged individuals tougher than the proponents of a "strong White Father in Washington" who gives security to all? Is the modern concept of welfare work as found in the policies of the Social Security Board as good as it appears to be, or should we expect further modification with the passage of time? Are backers of free enterprise different in emotional makeup from advocates of totalitarianism?

I am suggesting that we learn more about what is called the group; that we integrate the work of anthropologists, sociologists and psychologists, concerning mass reactions; the effect of inter-personal relationships; the effect on man of belonging to a society and how the intimate details

of that society with its inheritance, its mores, its protective mechanism affect men singly or in large numbers. We would know the various factors operating to influence or produce mental disease and personality disorder.

A comprehensive survey on all factors such as those mentioned above should be planned to extend over a longitudinal section of the nation's life. It should be in the hands of a committee of experts, representing all phases of society. It should work for five or ten years and come out with reliable information.

(2) What are the available assets? An early part of a planning program would be a study of available assets. All hospitals in the country—state and federal hospitals and private hospitals—should be surveyed to determine exactly what is going on. It would be valuable to get together the good points and bad points of existing institutions. See what is needed to bring them up to a set standard, in equipment, personnel, treatment methods. Perhaps a coordinated effort would succeed better than isolated individual efforts. Such a coordinated drive might produce an increase in state and federal appropriations—certainly it would aid in a proper sharing of what little personnel and money there is. Duplication in special projects could be prevented, greater teamwork inaugurated, more personnel trained and better care of patients achieved. If the present method of cost accounting could be changed from cost of patient per day to cost per patient per treatment period, it would be shown that economy that prevents adequate treatment and produces permanent hospitalization is false economy in the long run.

(3) What are the functions of each of us in solving the problem? In long-time planning for mental health, it is important to know who is responsible for carrying out any plans that may be devised. Does mental disease belong with tuberculosis and venereal disease as a major public health hazard, to be turned over to the state, as they are? Should mental health be the responsibility of government, professional or volunteer organizations, or individual doctors? If government, should it be federal or state or country or municipal? Among organizations one thinks of specialty groups, representing psychiatry, neurology, psychology, nursing, social work, and similar organizations, physical medicine, occupational therapy, dietetics, also the National Educational Association. There are the two great volunteer groups—National Committee for Mental Hygiene and the new National Mental Health Foundation. Alcoholics Anonymous is making a great contribution in one field. There are the great foundations, contributing to medical problems of their own choice. There are the great religious bodies exerting a profound influence on human behavior and welfare; the fraternal groups—Masons, K of C, civic groups, veterans'

organizations; great bodies of organized labor and the rapidly organizing employer groups with their interest in the welfare of the constituent members.

(4) What are the proper functions of various professional groups? Much clarification needs be given to the problem of who is authorized to treat mental disease and personality disorder. The present status of those assuming a therapeutic role is confused. Doctors are legally entitled to practice medicine and surgery—these terms include all specialities in the medical profession. And in some states psychologists are licensed to engage in private practice, the nature of which is not well defined. Others are also interested in treatment phases, especially in psychiatry—social workers and psychologists feel they should be assigned a therapeutic role and not be treated as technicians only. It is obvious that the real pleasure in medical activities is in the patient-doctor relationship, and having a share in working with the patient directly. This is understandable, and should be recognized.

In the Veterans Administration we have arrived at a decision as to what part in the therapeutic process is to be assigned to clinical psychologists and medical social workers. The essence of the position we take lies in the training and experience and ability of any individual clinical psychologist or social worker We recognize the position that each worker desires, assign a share of therapeutic responsibility and place limits on the extent to which non-medical people shall go. The doctors have made the decision as to when to delegate responsibility because under present laws this responsibility rests with us.

(5) What is the value of the team concept? A most important concept in modern psychiatry is the use of teamwork in giving the patient "good medical care." Modern diagnosis and therapy is not best accomplished by an individual psychiatrist. All patients need careful social service and psychological work-up and follow-up. Nursing is essential in hospitals and the visiting nurse outside. A skilled psychiatrist who knows the functions of the nurse, social worker and clinical psychologist, and has some experience in group work, can adequately handle five to ten times as many patients as he can alone. He can not only care for more, but the quality of care is markedly enhanced. Outside of the inner circle of four I have mentioned, the team also includes all the groups of people who come in contact with the patient—in hospital gatekeepers, guards, receptionists, volunteers, those in occupational therapy and physiotherapy, recreation specialists, the families of the patients.

(6) Where does psychiatry belong in the field of medicine? Any plan for meeting the psychiatric problem of the nation should include the proper orientation of psychiatry in the medical world. Modern concepts in psy-

chiatric treatment call for less isolation, more participation by men in other specialties, more emphasis on early acute treatment, more of what in the war has been called rehabilitation to start with earlier phases of convalescence. As more and more emphasis is placed on psychosomatic conditions, it is more than ever necessary for psychiatrists to be in close contact with all branches of medicine and surgery. This makes for better psychiatry, better medicine and surgery, and better doctors in all fields.

Furthermore, all doctors should have a great deal more psychiatry in undergraduate medical schools, and all postgraduate specialization should include a large amount of psychiatry, even in the sub-specialties of medicine and surgery. General practitioners, in particular, should have considerable training in psychiatry. They probably see the bulk of nervous cases, and almost always see them first. They should not refer all such cases. Many should be handled in the general practitioner's office.

(7) What is the importance of a teaching program? It is recognized that the best hospital care is found where teaching is going on. All psychiatric hospitals should be near medical schools and should have an active teaching program. Each hospital would do well to have a teaching position created, and in this position, a doctor with teaching experience, who would correlate all teaching and special studies and clinical research. In the Veterans Administration we are happy to say all the above ideas are incorporated.

(8) Where can we find the people to do the work? The need for more personnel is now an old story. Long-time planning probably will show the need for a greater number of graduates in all the specialty schools. It will call for a much greater relative increase in the teaching of psychiatric principles in medicine, nursing, social work, psychology. It will alter qualitatively the curriculum of all schools, with orientation at least, and basic training often, in principles of psychiatry.

The personnel problem will continue to be acute. It will be economically as well as socially bad to accept every kind of candidate for psychiatric postgraduate training. Therefore selection of candidates will become important. The Veterans Administration has just made a grant for research to discover the kind of doctor who is likely to make good in psychiatry. I predict it will not be long before improved methods of selection will be common to all graduate schools and will extend to undergraduate schools.

The number of psychiatrists needed has been estimated up to 20,000. That means 40,000 psychiatric social workers, and 20,000 clinical psychologists, according to the generally accepted ratio. It may be that this number can be reduced if greater use can be made of other personnel. The reluctance of doctors to turn over therapeutic responsibility must be over-

come to make use of more people. But this point must be made: responsibility for life and death is a serious thing. A mistake may prolong an illness. Failure to diagnose and treat a condition in its early stages frequently means an early death or a life of torment for the sufferer. We believe the solution to most psychiatric disorders is bound up in a combination of organic or physical plus psychological causes, requiring basic knowledge of the entire body-mind machine. Real understanding of complex conditions cannot be obtained without long years of study and considerable experience. College, four years of basic medicine, general internship and several years of postgraduate training go into the making of a psychiatrist.

I believe that we doctors would welcome the sharing of responsibility—all we ask is that the person who wants to take responsibility for an ill individual, know what he is doing, come to his task well prepared, and be willing to pay the same price that doctors have to pay in terms of training, experience, and judgment. All professional people must pull together. We must do away with misunderstanding and jealousy and fit into the role in which we as individuals belong. I am sure there is no place where mental health is more needed than among professional workers among mental patients. Let us apply mental hygiene to ourselves for the benefit of the patient.

(9) With 19½ million veterans in mind, I ask, what will keep these men and women well? Much less is known about prevention than about therapy. The sick and helpless have a special place in our hearts and much of life's satisfaction comes from aiding others. But we are prone to yield to pressure, exhaust ourselves with the emergency and do little about preventing illness in those who are mentally healthy, and who are beginning life.

In the past, child guidance clinics have constituted the major effort in prevention. These are making great contributions, but there are so few of them, I doubt if they affect the national picture at all.

Meeting the patient before he gets to the hospital—that is, treating a condition in a mental hygiene clinic while still in its milder stages, is a well accepted method of preventive psychiatry. Mental hygiene clincs are most suitable for psychoneuroses which should never be hospitalized in a mental hospital—and only when serious in a general hospital. We are setting them up and they will be good examples of teamwork in the best sense. The big increase in such clinics which we expect to come from grants in aid to states and medical institutions from the Pepper-Priest Bill, will be a great addition to this form of preventive psychiatry. It is important that scientific checks be made on results in these clinics to see what they really accomplish. For our part, the success or failure of clinic

work on veterans will be judged by the success or failure in reducing the number of hospital beds that have been estimated from past experience, and in reducing the number getting compensation for illness.

(10) What is the relation of education to mental health? A good mental hygiene environment is obviously beneficial to children and efforts are being made to create this in all schools. Homes are breeding places of either happiness or harm. Parents, especially mothers, teachers, employers, foremen, personnel workers, all in charge of other people, need special knowledge to handle their charges. In these, education in mental health principles has to sift through an intermediary to reach the person needing help and direction.

We know that information and insight are of value to a person after he becomes ill. Much of a psychiatrist's time is spent in what is called re-education. What about giving all people, as part of their education, some personal knowledge of mental health principles . . . and adding psychophysiology to physiology; adding mental hygiene to classes in hygiene. I believe this to be a useful field to work—but there are many who are pessimistic. They say to understand the nature of fear does not remove a danger. There are many of us who believe that understanding the nature of fear will reduce the fear, prevent it from being repressed, and often keep normal fear from changing into neurotic anxiety.

It may be that one of the most fruitful elements in preventive psychiatry may be found in clinical psychology. Better methods of diagnosis, to supplement experience; more understanding of personality makeup in normal and abnormal; and better methods for evaluating results of therapeutic methods are all available from the field of clinical psychology.

Prevention of mental diseases—achievement of mental health for an entire nation calls for the greatest possible effort, and coordination of all possible sources of aid. We must somehow marshall the energies, imagination and cooperative effort of all groups of society. Man does not live by bread alone—he must have a good inheritance, freedom from disease, contentment, opportunity, freedom of expression, a degree of emotional satisfaction, some outlet for instinctive drives, a chance to grow and expand, some form of security, and a relationship with the Supreme Power of this universe.

Man does not live by bread alone—but he must have bread or he will die. Bread includes roofs, and dollars, and clothes, and some assurance that these will be available for minimum requirements.

The state of the country will determine much of the successes and frustrations of its citizens. This is a tremendous force in adding to or reducing the burden of living. Socio-economic laws are complex and baffling, but we must take all these things into consideration in national planning.

SOME NOTES ON THE PRIVATE PRACTICE OF PSYCHIATRY

By SOL WIENER GINSBURG, M.D.†

It is extraordinary how little attention has been paid in the literature to the private practice of psychiatry by those who engage in it. The work of clinics, hospitals, research institutes, mental hygiene societies, etc., are all more or less adequately presented but a single paper* represents the whole of recent literature devoted to the problems of private practice, as far as I can discover.

The psychiatrist engaged in private practice has a unique opportunity to help inform the public and especially to help undo the many misconceptions of psychiatry now widespread among the laity and which come to his attention almost routinely. A fruitful relationship with the families and friends of his patients, as well as a demonstration in kind of the proper utilization and limitations of psychiatry can enrich the knowledge and awareness of very considerable and important segments of the population. As part of the wide educational program with which we are now attempting to mobilize all our resources, it seems opportune to direct some attention to this hitherto quite neglected aspect of psychiatry.

In good measure this communication deals with my personal experience and a word of explanation is indicated. Mine is an averagely active practice, devoted largely to intensive psychoanalytic psychotherapy and to consultative practice. In the five months from January to May of 1946, I carried from six to nine patients in more or less intensive treatment situations and saw in that time ninety-six new patients. It is on this fairly small but I think representative experience that this paper is based.

Of this number I saw seventy-one on but a single occasion; the remainder from two to five times before suitable disposition was made. They were referred to me for the most part by colleagues; five by social agencies; two by the Veterans' Service Center; eleven by old patients and four by lawyers.

Attitudes toward Referral to a Psychiatrist

Of the patients referred by internists, the degree of their understanding and their acceptance of the referral reflects, in the first place, the care and skill devoted to an explanation of its purpose by the physician. It so happens that many of my patients are sent to me by colleagues whose understanding of the nature of psychiatric consultation is better than average and whose knowledge is more than usually sophisticated. The

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* Muncie, Wendell, Observations on the Private Practice of Psychiatry, *American Journal of Psychiatry*, 102: 111, July 1945.

patients referred by these men have practically without exception an excellent understanding of the purpose for which they have been referred and, in general terms, what they may hope to gain from the consultation.

On the other hand, I see patients referred in an entirely offhand way who arrive with little information as to the purpose of the consultation or who have been persuaded to come to me as a "nerve specialist" and have been "reassured" (sic) that I was not a psychiatrist.

In all the years of my practice I can reckon on one hand the instances where that strategem has succeeded. I urge all colleagues who consult me in advance about using this device to avoid it and to spend more time with the patient preparing him for consultation. An obvious exception to this is in the case of psychotics seen essentially for decision as to suitable hospitalization. Practically all patients are now sufficiently "educated," if only by the movies, to recognize a psychiatrist's office and thus see through the falsehood at once. A doctor recently referred an adolescent girl to me, nominally for "educational guidance," as she had refused to go to a psychiatrist. She walked into the office, took one quick look around, said haughtily, "Oh, Lady in the Dark stuff," and exited without further ado. Subsequently, a wise pediatrician spent considerable time with her discussing her problems; she finally consented to seek treatment, only requesting that she be sent to a woman psychiatrist and is now in analytic treatment with every prospect of cure.

In all fairness to the physician, it must be emphasized that as far as I can see, each time he ventures a referral to a psychiatrist, he risks ensuing hostility not only on the patient's part but by the family as well and not infrequently a loss of both patient and family from his practice. It is not enough for us psychiatrists to be superior and condescending about this, hewing (for others) to a quite unreal, theoretically ideal concept. Nor is it by any means only matters of economics that deter a physician from making a suitable referral in proper time.

We still have a tremendous job to do in educating patients and doctors in the nature of our work and its meaning and true potentialities. My experience underscores the fact that mental and emotional illness still stand in the position that tuberculosis did not so long ago, to be assiduously hidden and denied until recognition and care can no longer be postponed.*

* The last patient included in this series is a 43 year old woman who had a moderately severe depression. For months she was treated at home largely with sedation and hormone therapy and by several physicians, each of whom in turn recommended that a psychiatrist be consulted. Because a daughter was about to become engaged to be married, the family consistently refused out of fear that the prospective groom might be frightened off from marriage. The woman finally made a serious suicidal attempt. It was the prospective son-in-law who arranged for the consultation, and, drawing on his experience as a GI, reassured the family about psychiatry and the hopefulness of its ministrations!

Time and again a physician persuades a patient to consult a psychiatrist only to have the patient return disappointed and confused by the difficulty in arranging even for a consultation. A colleague-friend told me recently that one of his patients called twenty-two psychoanalysts on a list he had given her before she could find one who would accept her for treatment. Another friend (an internist, exceedingly well prepared to make proper referrals) told me he has practically discontinued referring patients to psychiatrists. "I spend much valuable time explaining to the patient the necessity for seeing a psychiatrist; I spend more time finding a suitable person, only then to have the patient return and tell me, "Dr. X has no time and suggested I wait or go to Dr. Y and you'd told me Dr. X was a very fine therapist and didn't mention Dr. Y, and now what?'" "More often than not," continues my friend, "Dr. Y, now 'sold' to my patient, turns out also not to have time and so on, until the patient and I give up in disgust while I return to what I know to be inadequate, incomplete placebo therapy."

The now quite routine procedure whereby one psychotherapist refers a patient to another therapist for reasons of time and/or the inability of the patient to pay the required fee is a matter not easily understood and accepted by our medical colleagues and certainly not by most patients. In general, I find only a beginning acceptance of the time limitations in psychiatric practice and the impossibility of "squeezing" an extra patient into a day already fully occupied. Only recently a sincere and generally well informed colleague, disappointed in his quest for a proper therapist for a patient, asked me to explain why we felt we had to give forty-five or fifty minutes to a patient session. "Granted that is the ideal, shouldn't you psychiatrists of all people be more flexible and, in the face of current shortages, try to see more patients for less time? And, incidentally, at a smaller fee?"

Certainly all of us have now discovered the possibility of doing excellent therapy without seeing a patient five or six times a week. Without any formalized concept of "brief" therapy, the exigencies of the situation forced us to see patients once or twice a week and, although many of us had been doing just this in hospital clinics for years (and for only twenty to thirty minute sessions!), it came almost as a shock to realize how well it worked in one's office.

I have had no personal experience with group therapy and I am still not persuaded about its usefulness in civilian practice. It is very difficult for me to grasp how it might work in private practice and I await eagerly the experience of more venturesome colleagues who are now undertaking group practice in their offices.

The matter of fees is a highly individual one and, as medicine is now practiced, a matter of personal needs and attitudes. To judge from my own

experience in New York City today, because of the expense, adequate psychiatric care is available only to a small percentage of those who want it. Of the ninety-six patients here reported, I thought fifty needed more or less intensive psychotherapy. Of these, twenty could afford with more or less difficulty as full a program as I suggested; sixteen could afford "something," usually much less than seemed desirable. Fourteen could afford so little over a period of time that it would have been wiser and fairer to have referred them to a clinic. Often, however, they earned too much (all things being relative!) to be eligible for a clinic.

In addition, there is a great dearth of clinic facilities, especially those which accept referrals from sources outside the hospitals to which they are attached. There are also geographical restrictions which make clinic referrals difficult. And what is perhaps most serious is the fact that with very few and as yet insignificant exceptions, the psychiatric clinics meet during the day, often requiring loss of pay and at times simply precluding clinic attendance for a working person.

The factor of time mitigates against the easy acceptance of psychotherapy even among those who can afford the expense. Men and women who work can seldom afford the ninety to one hundred minutes of a working day that a visit in New York City requires. Relatively few people can regulate their working day to include so long an absence with any frequency and regularity.

Of course there are other and more profound factors involved in this phenomenon. Unconscious factors of resistance; too long antecedent therapy on an organic, pharmacological basis and plain ignorance are all variously involved.*

One factor that makes for much difficulty is the fact that many physicians simply do not know which patients to refer—and this applies in the direction of over-optimism as well as skepticism. As long as medical education is so deficient in its teaching of psychiatry, we must expect this condition to continue.

For instance, to give but a single example, most physicians with whom I have dealings still believe the equation "neurotic = curable; psychotic = incurable" and it is very difficult for them to accept that a neurotic process may be entirely irreversible and untreatable and that not every psychotic need be continuously institutionalized.

* In this connection, the report of a study done under the auspices of the New York City Committee on Mental Hygiene of the State Charities Aid Society on "The Needs for Psychiatric Care among Neuropsychiatric Rejectees and Dischargees" is significant. In the sample we studied, eighty-one per cent of the men were thought to need some form of psychiatric assistance but only about twenty-five per cent of this number were able to admit their need and seek help. The report discusses the problem at length and will soon be available.

I see a fair number of patients (seven in this series) who need psychotherapy and who live forty to two hundred miles from New York City. For them the problem is even more difficult as few of these neighboring towns have any psychiatric help available. It is encouraging to be able to report that some psychiatrists returning from service are wisely settling in these nearby places.

Patients' Attitudes to Psychiatry

In recent years and especially since the first glowing reports of psychiatry in the armed forces began to appear, a new phenomenon presents itself daily. There is no question that we have now oversold certain aspects of psychiatry; patients of little education and knowledge ask with quite some assumed sophistication about hypnoanalysis, narcosynthesis and especially shock therapy. Time and again I see patients with mild depressions, for instance, and indicate the usual simple therapeutic devices that so often suffice in these cases, only to have the patient, the family and/or the referring physician demur because I have not suggested shock therapy.

It so happens that my personal experience with shock therapy has been quite disappointing and while I am impressed by the optimistic reports in the literature, I do not find the results duplicated either in patients I refer for such treatment or in those who obtain it without my approval and of whose course I subsequently learn. I view the use of shock therapy in ambulatory patients with many reservations, especially since it is now often given at the request of those entirely unqualified to decide as to its suitability. I might mention, in passing, that of this group of patients, five had shock therapy, with some improvement in two. My own overall experience has been even less satisfactory.

It is most difficult in private practice to persuade families and doctors, much less the patient himself, that shock therapy should practically always be considered only as *part* of treatment and not its entirety, and that some attempt at psychotherapy is, in many cases, a more vital part of the therapeutic regime.

Hospitalization of Patients

Ten of this group of patients were hospitalized in four different hospitals; two patients going to state institutions,* the others to private hospitals.

* In the last few weeks since the appearance of a series of "exposures" of conditions in mental hospitals, I have suggested hospitalization for three patients whose circumstances required their referral to state institutions. In all three cases it was flatly refused on the basis of what they had read. Whatever the merits of this type of publicity, the effect on patients and their families is not to be overlooked in the quest for reform from the outside. If psychiatry were more vigilant and aggressive in protecting the needs of mental patients, it would not be necessary to resort to this sort of propaganda.

The psychiatrist who refers his patient to a private hospital with which he is not connected (and very few psychiatrists in New York City serve on staffs of psychiatric hospitals to which they can refer private patients) receives a reception varying, in my own experience, from the utmost friendliness to calloused discourtesy. But, whatever the personal unpleasantness may or may not be, he surrenders all but a purely verbal participation in the care of the patient. I realize how this almost inevitably occurs in hospitals with full time staffs which assume full responsibility for the care of patients accepted by them; it remains, however, a serious drawback on two scores. In the first place, one cannot treat or even supervise the treatment of one's own patients; secondly, it is very difficult for the average layman, accustomed to ordinary medical and surgical practice, to understand how a psychiatrist, who has usually been built up in his mind by the referring physician as a person of repute in the community, must surrender all control of the patient brought to him for care. As Muncie pointed out in his recent paper,* this usually leads to the hospitalization of patients in unsuitable institutions where the doctor does have "privileges" or to the continuing ambulatory care of patients who could be more adequately treated in a suitable hospital.

The average cost of care in a proper mental hospital ranges from sixty-five dollars per week upward, a cost far beyond the means of the average middle class family, especially when one considers the usual duration of the hospitalization. Many cases are treated on an ambulatory basis where the psychiatrist recognizes the need for hospital care but where hospitalization in a state institution is refused and private care economically impossible. In addition, I find in practice the persistence of the most archaic notions about psychiatric hospitals. The legend of stigmatization is especially hard to defeat and much more reeducation is obviously needed to correct such impressions.

On Service People Seen in Practice

In this group of patients seven were recently discharged and two were still in service. Only one of the seven veterans had been a patient in a service psychiatric installation and, although he was a seriously disturbed hysteric, he too had been discharged on points. He succeeded in denying his symptoms long enough to be returned to duty and home, so great was his feeling of dread that he might be further labelled a "psycho."

The other six patients all had had fairly long and successful service records, only to develop symptoms requiring care on discharge. Interestingly enough, one of them was a man I had seen ten years ago on one occasion because of difficulty at school. His Rorschach at that time re-

* Muncie, *op. cit.*

vealed a severe hysterical pattern. He had had no therapy; his Army record is one of unusual brilliance. Only on his return to his home where he again came under the influence of hostile attitudes, parental and otherwise, did his symptoms reappear. The syndrome of homecoming "jitters" and depression is now a familiar one. It is fascinating to speculate on the psychopathology which permits a man to go through four years of untold hardship and danger without a day's sickness, only to be depressed and miserable, irritable and fractious when "safe" at home again.

The following table summarizes the diagnoses* in these 96 patients.

Psychoses	
Schizophrenia	13
Manic Depressive Psychoses	
Depressed	4
Manic	1
Reactive Depression	3
Involutional Melancholia	1
Paranoia	3
Senile Psychosis	2
Post-partum psychoses	3
Psychoneuroses	
Anxiety neurosis	7
Obsessional neurosis	7
Anxiety Hysteria	5
Conversion Hysteria	5
Mixed Neurosis	5
"Character Neurosis"	3
Neurotic Depressions	3
Psychosomatic Problems	
"Anorexia Nervosa"	2
Anginal Pains	1
Hypertension	1
Healed pulmonary tuberculosis with continuing symptoms	1
Ulcerative colitis	1
Consultations concerning members of the family	8
Marital problems	6
Alcoholism	5
School problems	5
Consultations concerning employability of person	1

I do not wish to extend this paper to a clinical discussion of the material. I would comment merely on one fact. Increasingly, I find people referred to me for preclinical problems, so to speak. Marital tensions not yet serious but threatening difficulties; business problems reflecting neurotic difficulties; school failures recognized early and not explicable on the basis of poor intelligence; personnel problems; and other similar situations. In some of these we can offer a most gratifying service and I believe this is a field which justifies much more investigation.

The psychiatrist in situations such as this should be a bit of a friend, healer, practitioner and scientist; the adequate management of such situations requires an ability to tread lightly and yet deal forthrightly with immensely complicated problems.

It is a frightening fact to note how many of one's patients have been long treated for difficulties entirely unrecognized as emotional until they

* These are simple "working diagnoses" and make no pretense to scientific accuracy.

finally find their way to a perceptive physician. Of the ninety-six cases here reviewed, thirty had been seen by three or more physicians before reaching the referring doctor. I have no way of knowing, of course, how many of them recognized the psychiatric aspects of the problem. Suffice it to say that, whatever the reason, there had been no approach to these elements in the case.

Conclusion

The psychiatrist in private practice has a wonderful opportunity to do an important educational job with both physician and laity. It is important that we do not overlook it in our preoccupation with the more directly clinical aspects of our practice. Although the care of the patient must naturally always be our primary consideration, we should try to remember that in turn each new patient affords us a contact which can be suitably utilized to inform and educate a group in the community. In the aggregate of our efforts, I believe this can be of immense value.

MODERN CONCEPTS OF WAR NEUROSES*

By BRIGADIER GENERAL WILLIAM C. MENNINGER, M.C., A.U.S.

As a conservative estimate, there are at least a million more people in this country tonight than there were three years ago, who have heard of, have dealt with, or are personally concerned with that medical entity called psychoneurosis. Many millions more are familiar with pseudonyms for this illness—operational fatigue, combat fatigue, combat exhaustion. From the language of the G. I., one could add more terms descriptive of neurotic reactions such as gang plank jitters, slap happy, bomb happy, reple deple exhaustion, etc. We in medicine are confronted with the fact that the membership of the military and their families at home have become increasingly educated on this subject, for better or worse, during the last three years. It is now a paramount responsibility of the medical profession, not only to correct much of the misinformation that exists, but far more important, to understand and effectively treat this illness. There are many former soldiers among the three hundred thousand odd veterans who have been discharged from the Army because of this illness who will need medical help.

There is a certain incongruity in the fact that it was the war which directed such a bright spotlight onto neurotic illness. Certainly no medical condition which occurs in civilian life can compare in incidence with the psychoneurotic problem, the origin of which lies in the conflicts caused by the pressure of everyday activity, the competitive nature of economic and social life. About fifty per cent of all who go to a physician present primarily emotional difficulties that correctly classified are some type of psychoneurotic reaction to the problems in their lives. With this civilian background, it is not surprising that the strenuous existence of the Army precipitates further neurotic expressions. Thus, life in the Armed Forces focused conspicuous attention on this characteristic of the American people.

Even more significant than the large number of individuals who are diagnosed by the doctor as psychoneurotic, is that sizeable segment of the populace which makes a difficult adjustment to life, though never develops a neurosis. They manage to get along reasonably well only because of some sort of support, some special indulgence, some particular type of relationship. There are many variations in such adjustments—the husband who lets his wife assume the masculine role, the wife who plays this role, the joiner and the hermit, the braggart and the gossiper, the daredevil and

* Given Oct. 8, 1945, as the Ludwig Kast Lecture, before the 18th Graduate Fortnight of the New York Academy of Medicine. Reprinted by permission from the Bulletin of the N. Y. Academy of Medicine, 22: 7–22, January, 1945.

the timid soul. They are the objects of our observation and comments in the closed circle of friends and family. They are not patients of any doctor and may be productive members of the community. They are, nevertheless, neurotic. We, those of us with any psychiatric insight, should not fail to appreciate that all the rest of us make use of neurotic defenses to some degree; always when under special stress of the environment and often when the stress is entirely internal.

With the psychoneuroses and the neurotic adjustment reactions, psychiatry is familiar. The growth in our knowledge of the understanding of the anatomy and the physiology of the personality has given us a reasonably clear picture of the mechanisms behind such relationships and behavior. It is the consensus of the great majority of the psychiatrists in the Army and the Navy, that the same mechanisms are operative in the military and that the same clinical pictures occur as we see in civilian life. Essentially, the response is the same when John Smith cannot adjust himself to the family at home or the artificially created family situation in the Army; when Paul Jones cannot stand the tempo of the factory and is unable to stand that of the Army.

There is, however, a group of reactions in the Army which does deserve special consideration because of certain features in the dynamics of its development that are characteristic. There are personality disorders occurring in the course of combat which, though not new, are at least different from those customarily seen in civilian psychiatric practice. It is this limited field to which I shall devote my attention.

Background for Understanding Combat Exhaustion

A prerequisite for understanding either pathological processes or pathological states is a knowledge of the normal. This entails not only anatomy but physiology and applies to the psyche as well as to the soma. In spite of the difficulty of condensing such an explanation into the time allotted here, it seems desirable to set forth certain fundamental facts regarding the personality and its functioning that are well known to dynamically oriented psychiatrists, in view of the fact that the main point of this discussion is psychopathology.

A child is born, as any other quadruped, primitive, cannibalistic, asocial and uninhibited. The personality at birth is endowed with the two recognized fundamental drives of aggressiveness and erotism, perhaps more broadly described as destructive and constructive urges, as hostility and love. With growth and training the personality develops its individuality with a conscious regulating portion which becomes the ego. The child learns to curb his instinctive infantile behavior through the training and supervision of his parents. Initially all restraint is exercised by these ex-

ternal powers. The child learns to control his aggression and is rewarded with love. Beginning in his early childhood, he unconsciously incorporates this control function within himself and psychologically includes this function of his parents within his own personality as his conscience.

When the personality is mature, failure on the part of the ego to control the aggressive impulse is always accompanied by anxiety. Consequently anxiety comes to be a signal of disturbance within the personality. The impulse acts as a threat to the security of the ego which has from experience the foreknowledge of the disapproval from the conscience. The picture becomes complicated when there is, in addition to the internal threat, an external threat in the form of danger. Psychiatrically, it may or may not be rather simple to differentiate anxiety which arises because of a disturbance within the personality from the apprehension or fear that arises from the external situation. Thus, the compulsive individual often may manifest anxiety without any external danger or threat. In some instances, we see great apprehension or fear due entirely to external danger which superficially may resemble anxiety. Or they may be combined, as in the case of the combat soldier.

Thus in a very over-simplified condensation of the dynamics of anxiety, we see that its origin is the unconscious aggressive impulses which threaten the ego which if it fails to control them is criticized by the conscience. The conscience also becomes of special significance to the combat soldier, in that its critical faculties of certain behavior are relaxed and its individual idealism or code is, to some degree, displaced by the group code. Its development, and in fact the development of the total personality, is subject to many variations with numerous potent influential factors.

The relationships of the soldier with his father and with his siblings may both greatly influence his acceptance of his military role. Ideally the child likens himself to his father, following an initial and important struggle in his orientation toward authority. When this identification has been relatively smooth, the son accepts the role of submission to this father authority, becomes dependent upon him and borrows psychological strength from the process. Where the ideal role has varied and the son has developed no identification, where he has continued to resent the father and his authority, one must expect difficulty in all subsequent situations where the individual must be subservient to a father figure. This has frequently been encountered in the adjustment of the soldier to his leader and is of special significance for the man in combat. Except as eccentric daredevils, such soldiers are a liability in combat, but only a small minority fall in this category. The great majority transfer their original unconscious relationship toward the father to their commanding officer.

Further complications in the development of the personality are of

special importance in some soldiers. Even in ideal maturity, recognized unconscious patterns of reaction exist between siblings. Associated with these are positive and negative feelings of affection and hostility. In the soldier's situation, the buddy may unconsciously come to represent a particular sibling and his reactions are, to some degree, predetermined by his relations to his true sibling. Sometimes there is a strong attachment with minimal negative feelings and sometimes a strong attachment despite strong negative feelings. Army life in itself is often conducive to very strong attachments between men. They share training, experiences and dangers. When one is wounded or killed, such experiences alone may explain much of the reaction. On the other hand, where a previous sibling relationship existed in which there was unconscious hostility, this may be the chief determining factor in the symptomatology of a breakdown. One must postulate that in all cases, the early family relationships condition the soldier's behavior toward his associates.

One must not ignore other factors operative during the formative period which have also influenced the pattern of the soldier's personality. These make up the total social environment in which he grew up to function as an individual. Civilization represents an extension of the original parental influence as a curb of the primitive man, which aims toward social maturity of his group. For the soldiers in this war, there were many special national problems and attitudes present which directly influenced their childhood and adolescence. Some of these were parental unemployment, the struggle of democracy versus dictatorship, an isolationism in attitudes of our people toward the rest of the world. There were the good and the bad effects of radio, screen and transportation speed which developed concurrently with the soldiers of this war.

In addition, the tradition of the American culture is to produce a personality with emphasis on individualism and independence. Deeply ingrained self-respect and a high degree of self-determinism were American characteristics and these were coupled with a free and unrestricted privilege of self-expression. Such were the influences to which the personalities of our soldiers were subject.

New Environmental Stresses in Becoming a Soldier

Pearl Harbor caught us unprepared to aggressively express ourselves in war against another nation. In contrast to the belabored debate of the months preceding, as to whether or not the show in Europe was any affair of ours, the psychological effect of Pearl Harbor on the nation was to cement us into a singularly unified attitude. Unfortunately, before many months had passed, that unanimity of opinion and determination of purpose became somewhat decimated and vague. At the same time, men were

regularly and speedily taken into the Army in large numbers. What was their motivation as they joined the Army? One has to conclude that in a great majority of instances these men, being law-abiding citizens, came in because it was the will of the country. Not a few had a resigned attitude, and undoubtedly the lack of emotional tone in the populace at large led many to feel that fate had played them a poor game. They went because it was their duty, but rarely with enthusiasm or conviction.

When the man became a soldier, there were changes in his external situation which demanded major readjustment. He gave up his normal gratifications almost entirely. He had to accept separation from his family, his home, his job, his friends, with little in prospect except the possibility of adventure. He had to give up his individual identity and become a member on a team, with the only reward being his identification with that team. He had to accept severe privations in return for very restricted gratification.

For that group of men who had to go into combat, there was another series of adjustments required, those for which there is no parallel in kind or degree in civilian life. The personal danger surrounding the combat soldier made all other adjustments pale into relative insignificance. The necessity of throwing over all previous ideals, not only of his own conscience but of the group conscience to accept the requisite of killing to avoid being killed was a greater change than many people realize. Frustration was a daily part of his life, sometimes in the form of waiting—days, weeks, months; sometimes in the deprivation of essential supplies. Confusion was routine in his life and the noise and whistles and flares of battle are beyond the imagination of anyone who has not heard and seen them. Insecurity was constant, not only in his personal doubts of himself, but also the doubts regarding his orders, doubts about the leader's ability, and knowledge, doubts as to whether the higher-ups understood and would act, or permit him to act. In addition to all this, was the extreme physical discomfort, the loss of companions, the ever present pain and death.

All of these factors operated on the personality and it is amazing that so many American men tolerated them so effectively. There were comparatively few compensations, few supports against all these pressures. But without question it was these supports that enabled them to function. Probably the most important of them was the leadership of the unit. Psychologically the leader is well recognized as representing the strong father figure who is interested in the individual, who is looking out for him, who is considering him, who knows what he can do and actually leads him. Nearly as important as the leadership, however, was the group identification, the esprit de corps created by close association, the common aim and mutual sacrifice. Many soldiers freely admitted that it

was chiefly because of their feelings of loyalty and devotion to their associates that enabled them to go on. Their individual civilian-life conscience was displaced by a group conscience, which served both in a positive and negative fashion. Positively it gave them permission to kill, a behavior antithetical to their entire life ethics and training. Only through group permission and approval could they do it and even then it was often very difficult. The group conscience supported them in a negative way—it prevented them from quitting because of the fear of group disapproval. The close personal attachment to and dependence of a soldier on one or more members of his group, his buddies, was a very important force in maintaining his combat ability.

Other definite aids to the withstanding of the external stresses of combat were the soldier's training in discipline and obedience and along with it the confidence in his own ability and in his weapons which was developed through such training. He was sustained by his own physiological responses, the result of stimulation by excitement of the autonomic nervous system which enabled him to be aggressive. A minor, but in some instances an important reënforcement, was the glorification of the mission in which he was partaking, a glorification which in the extreme made even death seem a little less unattractive; at least he faced the prospect of a hero's death.

Psychological Changes in a Soldier to Meet These External Changes

While one may enumerate the various supports and compensations which helped make a soldier able to face combat, they alone were not enough. Less apparent dynamic changes in the personality were necessary to effect adjustment. It is important to recognize that in the majority of instances these changes are unconscious and therefore automatic, but without a doubt must occur for the individual to effectively meet the demands made upon him. The first of these is to change from his civilian independence with initiative and self-expression to a dependent role of submission to leadership orders and group requirements. Granted that the soldier has an opportunity, in a limited degree, to develop his individuality in certain isolated instances, the winning of a battle demands that the good soldier rely on his superior, and that he accept and carry out his superior's orders promptly and exactly. He must therefore accept a predominately dependent emotional role. This acceptance, while difficult for some, is welcomed by others. In any event this change may bring unconscious satisfaction in that it requires the man to shed responsibility, to live on the decisions of others, to have his daily life planned, to passively be the recipient of his food, his clothing, his shelter, such as it is.

This passive relationship grows more rapidly and becomes acceptable when the soldier feels secure through his confidence in the symbolically

all-knowing, all-powerful father, his commanding officer. Subservient to this officer and under his direction he learns to modify a lifelong constructive drive in order to allow the functioning of a primitive, destructive one. Only with this help can the average man shift from a constructive civilian life to a chiefly destructive soldier life. Even so, the change is so difficult that severe psychological problems arise.

Many soldiers never had to make the psychological adjustment to the process of actual killing and seeing the result of their aggression. The bombardiers, the artillerymen rarely, if ever, saw the result of their work at close hand. In contrast, the infantry soldier often, if not regularly, was in a position to observe his effectiveness. Because of this there were many instances when soldiers who could not bring themselves to kill, even under the pressure of facing leader and group censorship, became ill from the psychological conflict involved. In other instances, a soldier might reach a saturation point, a limit to his ability "to take it"—referring specifically to his necessity to kill.

Other factors come in play in those occasional situations where hand to hand combat takes place. There the imminent external threat is sufficient to overcome the influences of the conscience, even in those who under less threatening circumstances found difficulty in killing.

Another dynamic change in the functioning of the soldier's personality is the necessity to shift his investment of affection from individuals to a group. Throughout his life he has had a fixed and more or less constant association with certain individuals—mother, father, siblings, wife, children, long-time friends, with whom he has shared love and interest. They have been, quite literally, his world. These he must temporarily set aside and from them he must shift, for his immediate investment of affection and return of interest, to a strange heterogeneous group of men, to a diffuse group love in contrast to his previously specific individual love. Certain members of the unit gradually become his inner circle, and maybe his chief support, but the major identification for an effective unit must be made with the group and he must fuse himself with it.

This review of the dynamic forces in the life of the soldier about to go into conflict indicates that he must accept an emotional regression to an earlier developmental stage in order to permit his acceptance of the essential dependent passive role. This does not imply that he must make an intellectual regression or that the whole procedure is accomplished with considerable insight. It is nonetheless through such regressions that he can mobilize and express the primitive aggressive drive present in everyone of us which is essential to the functioning of a fighting man. This regression in no sense lessens his need to protect himself and undoubtedly the external threat is a major stimulus to the expression of this aggressive drive.

It is through the full approval of the good (father) leader that the dictates of the individual and personal conscience can be ignored. If either the leader or the group approval is not constant, the soldier's main psychological support is lost. Consequently, we must recognize that the soldier, even before he starts combat, is in the predicament that not only is he faced with an extremely dangerous external threat but with a potential internal threat.

The Development of a Neuropsychiatric Reaction in Combat

One must see the combat casualties in this stage setting. In general, there are two large groups of reactions with no sharp dividing line: first, those individuals who are grossly predisposed to maladjustment, and second, those with minor or no apparent predisposition. In the first group, the combat casualty presents a familiar neurotic response, similar to the picture seen in civilian life. Even though the soldier had succeeded in making a passable adjustment to all his pre-combat training, the stress, and usually some specific feature of combat—upset the balance of his equilibrium. Such patients initially present typically neurotic defenses—conversions, obsessions, psychosomatic complaints, etc.

In both of these groups one may observe various devices used to protect the individual against his anxiety. Many soldiers adopted a fatalistic attitude expressed in the remark, "one of them has my number on it and when it comes, it comes." The utilization of omens, charms was common. These all represented a magic protection of the ego and were common to all soldiers. One could discern cumulative effects of various events although the anxiety is controlled. With increasing fatigue, one might often note a slight impairment of the individual's judgment, his tendency to carry out repetitive activity, such as jumping in a fox hole without adequate testing of the reality situation. Such automatic responses were even active in places of relative safety. In many instances a narrow escape, the death of a platoon member were contributory. A very common observation was the case of a wounded man who only began to develop anxiety as his wound healed and he was confronted with a return to combat duty.

A second group of soldiers, certainly the majority, appear, at least superficially, to be normal personalities reacting to abnormal stress. They give no history of previous maladjustment in civilian life, no history of distress to themselves or their family. However, these soldiers must have some predisposition, minor though it may be. Undoubtedly, the outcome of their reaction to combat depends on the degree of this predisposition. It is gratifying to know that the majority, probably the great majority, responded sufficiently under appropriate treatment to permit them to

carry on. That their experience leaves scars, there is no doubt, but certainly in many, these scars are not sufficient to seriously or permanently disable them. Our figures indicated that sixty per cent of the psychiatric casualties from combat were able to return again to service in the Army area, and at least fifty per cent of these, in certain instances more, returned to actual fighting. We should have no illusions, however, about this group. The Army medical officer's function was to return the soldier to duty. Neuropsychiatric casualties, if adequately rehabilitated, were no less expendable than rehabilitated surgical casualties. If they were well enough to do further duty, that was their assignment, and many carried on indefinitely. The permanent effect of the Army experience, and specifically that of combat, on their personalities will only be known with the passage of time.

There is also a group of men, in whom the predisposition, even though not apparent on the surface, was serious enough so that they did not respond quickly to treatment. An additional larger number showed a delayed reaction; they completed their tour of duty and only then, under different circumstances, perhaps as they returned home, did their psychological battle scars manifest themselves. In every instance of these delayed reactions, there is very good evidence to believe that there was a specificity for the individual in the final event or situation which served as the precipitating factor.

Grinker and his co-workers very adequately describe the various types of regressive pictures based on their chief symptomatic expressions under the groups of passive dependency, psychosomatic reactions, guilt and depressive reactions, aggressive and hostile reactions and psychotic-like states.

The immediate clinical picture was colored far more by the combat situation than by the individual's particular personality. This was as true of the man who broke down in the first few days as of the man who broke after many months of combat. Their clinical pictures were remarkably similar. From a psychological point of view, such reactions were the result of cumulative stress. In both cases the man had reached his limit as a result of physical fatigue, the continuous threat to life, the single or repeated psychological traumata, all of which had exceeded his capacity to handle.

The clinical picture has been described by several combat experienced psychiatrists. The prodromal symptoms are most frequently irritability and disturbance of sleep. The individual is aware of his increased sensitivity, his "startle reaction," his involuntary self-protective motor responses to sudden noises. Sleep becomes disturbed because of sudden involuntary starting or leaping up because of noise stimuli or disturbing dreams. The soldier himself may recognize his symptoms or the man's

behavior or change in personality becomes apparent to those about him. He may become more seclusive and silent, or on the contrary, more talkative; he may be restless, may smoke excessively if the opportunity permits. He is aware of an increased apprehensiveness but paradoxically is less able to concentrate. He frequently shows somatic symptoms such as mild tremor, incontinence of urine or feces.

There was a monotony in both the complaints and the symptoms as seen by the physician in the aid station or by the psychiatrist at the clearing station. The complaints differed depending upon the stage of personality disorganization; in the majority of cases they followed a stereotyped pattern: "I just can't take it any more," "I can't stand those shells," "I just couldn't control myself." The symptoms varied only slightly from patient to patient. Whether it was the soldier who had experienced his baptism of fire or the older veteran who had just lost his comrades, the superficial result was very similar. Typically he appeared as a dejected, dirty, weary man. His facial expression was one of depression, sometimes tearful. Frequently his hands were trembling or jerking. Occasionally a man would display varying degrees of confusion, perhaps to the extent of being mute or staring into space. Very occasionally he might present classically hysterical symptoms. Some of them knew that they were "combat saturated" and that they might be through so far as fighting was concerned.

Such is the common immediate reaction, one that does not on its early symptomatology fit into any of our known diagnostic categories. For this reason, the widely used terms of combat exhaustion and operational fatigue have probably been very practical for their utilitarian aspect. They have the disadvantage of implying that physical exhaustion or fatigue plays a major role. It no doubt does contribute an influence, varying in different situations, but it was never possible to set up a series of physiologic experiments which might have given some index as to its actual effect. On the basis of broad experience, it has been estimated that not more than 3 to 5 per cent of the reactions were due entirely to fatigue. In the other 95 to 97 per cent the condition was primarily a personality disturbance and was treated as such.

The commission of five civilian psychiatrists who visited the European Theater in April and May of this year were united in their opinion that the picture of psychologic disorganization did not correspond either in its moderate or in its extreme form to any recognized or established psychiatric syndrome. They regarded the term "combat exhaustion" as a practical term to apply to this temporary condition, out of which various more definite and more familiar syndromes evolve. This diagnostic label does not apply beyond the initial state, and as such represents a transient

psychiatric reaction to combat, that may or may not progress to a more clearly defined clinical entity. Consequently, it has no applicability beyond the immediate response. It does not apply to the further evolutionary stages, the typical psychoneuroses, nor does it apply to the delayed symptoms so often seen, those typically regressive phenomena, in men who have completed their tour of duty, which occur at a time when the support of the group and the leader is gone.

Psychodynamics of Combat Exhaustion

The psychodynamics of combat exhaustion include four significant features: the depleted ego strength, the specific precipitating trauma, the mobilized aggression and the loss of the ego supports in the form of leadership and group identification. The depleted ego strength, the ability of the conscious personality is in every case cumulative, regardless of the length of combat. One must assume that certain types of personalities can withstand stress over a longer period of time than others, but the breakdown of the soldier in combat, whether it is during his first week or his fifteenth month, is related to his ability to withstand the stress, plus the avoidance of any specific psychological trauma which would overbalance his ability to adjust to the external demands. However, the cumulative effect is a major factor, so that whenever the specific traumatic event does occur, it may in some cases appear trivial. Just as in civilian psychiatry, though it is often not possible to discern the specific precipitating factor in the production of mental illness, there is much evidence to believe that it is always present. The soldier may or may not be able to describe certain events which may have been the final straw—the death of a comrade, the hopelessness of a particular assignment, a broken promise.

Two factors permitted the soldier to express his aggression. One of these was the external situation, the necessity either to kill or be killed. The other and probably the more significant, in the situations which were less immediately threatening, was the approval and command of the leader and the identity with the group which shared the common aim. When and if these psychological factors suddenly disappeared, one found the dependent ego with a high degree of activated aggression with no outlet to express it. In the very rare situation, the soldier might carry on alone; such were likely to be the winners of Congressional Medals of Honor. Much more often, with the loss of the leader and/or the group, the soldier was at a loss. The combination of his helplessness and his activated aggression invariably created anxiety.

It is the ego's normal function to maintain the integrity and equilibrium of the personality against both the external stress and the unconscious forces within the personality. It is helpful to think of the ego as having

a given strength, of a strong or weak ego, of increased or decreased ego strength. In the combat soldier, the continuing effect of combat accumulates and drains the ego's ability to maintain balance. In the specific traumatic event of the final wound, it must attempt to control a powerful aggressive impulse which it can now do with only limited success. Its failure gives rise to anxiety which, if transformed into symptoms, comprises the clinical picture—the irritability, the sensitiveness and jumpiness, the depression, the inability to concentrate or accomplish even relatively simple tasks, the dreams which recur so characteristically in the combat psychoneurotic personality.

In many medical conditions, even the pathology represents an unhealthy attempt to rectify or alleviate the cause of that pathology. This phenomenon is even more pronounced in psychiatry in which the symptoms are, in a sense, an attempt at a solution of a conflict. A special characteristic of some mental symptoms is the tendency to repetition, so brilliantly described by Freud as a repetition compulsion. This process is a conspicuous feature of combat exhaustion and is perhaps best illustrated by frequent similar dreams. The dynamic significance of the dreams, in general, is that they are an effort of the unconscious to resolve the conflict by mobilizing the anxiety to expression. Because the whole dream process is unconscious, the individual is not relieved and may be so disturbed by the dreams that the illness is aggravated. This creates a situation in which the individual is stimulated but is not permitted physical expression, and the more the physical expression is inhibited, the greater becomes the anxiety. Unless there is aid given to bring the conflict and its resolution to the conscious level and into reality, the neurosis continues. What was originally stimulated by an external threat becomes internalized and without help may become an insoluble vicious circle. The unconscious emotional pressure continues to produce anxiety in increasing amounts without conscious recognition of its causes.

Conclusions About the War Neurosis

In summarizing the main features of the war neurosis discussed above, one needs to remind himself that this group of reactions to combat represents only a small percentage of the total psychiatric problem of the Army. It does not include the neurotic reactions occurring in basic training, on boarding ship, in sitting on a lonely south sea island, in weathering a monsoon season in India. Nor does it include the 25 per cent of all types of discharges for psychiatric reasons because of warped character development. All of these groups are familiar to psychiatry and differ in no way from the same pictures in civilians except in the environmental situation in which they developed or became apparent. Very often they were re-

vealed only because of that situation; they might have gone unnoticed in civil life.

Only combat reactions, represent the true war neuroses. They too become apparent only because of the situation. They have been described as the normal response to abnormal situations in which the stress was far more severe than in civilian life. It is reasonable to assume that many men developed these reactions who might well have gone through civilian life without manifesting any gross maladjustment. Furthermore, many who did suffer from such traumatic experience apparently recovered quickly, even to the extent of successfully continuing the same severe test of adjustment.

In summarizing the dynamics of combat breakdowns, there would appear to be a combination of the severe cumulative external stress, a varying degree of predisposition, a peculiar psychological setting in which the combat soldier functions and a specificity of some particular event which precipitates the incapacitating result. Any or all of these may vary in each individual case, some of them being all important in one instance and inconspicuous in another. When the final straw is placed on the soldier's back, the immediate result appears very similar in all cases. Fortunately, with relatively little help the majority promptly readjust. For the remainder, and numerically the group is large, there was and will be need for further psychiatric treatment.

Only as we understand these dynamics can we understand the symptoms which we may see in the veteran patient. His weakened ego cannot handle the aggressive forces which have been activated. His solution is to regress to simpler functioning level. In some cases, instead of returning to his normal adjustment he remains in the regressed stage of development where he can express his passive dependency, his depression, his hostile reactions, his somatic complaints. He cannot explain his symptoms—his feeling of helplessness, his stomach disorder, his irritability and impatience, his tendency to fly off the handle, his failure to find satisfaction, his resentfulness of all but his own group. Some will return to civilian life with a tendency to feel that no one understands and with latent, or expressed, paranoid attitudes. They do return, in a sense, to a foreign atmosphere but their attitudes are not caused so much by this fact as by their personalities which are heavily burdened with the conflicts arising from their battle experience.

With this understanding on the part of the physician, treatment must be directed toward integrating the individual into his pre-war identifications and satisfactions. If he comes with emotional problems, with pent-up resentment which he cannot manage, these must obviously be released. With this release must come insight through psychotherapy, not only into

the immediate situation but into the origin of these emotions in their relation to previously formed personality patterns. What is the treatment and by whom should it be given? No simple set of rules can be laid down but some patients are going to require expert psychiatric care and others can certainly be helped and probably readjusted by the intelligent, sympathetic physician who has some psychiatric orientation. In other words, some patients, to borrow an analogy from surgery, will need major and others minor psychiatric procedures. The former should be carried on by an experienced psychiatrist, the latter could be adequately directed by a general practitioner or a specialist in another field.

One might generalize by saying that if the patient has made an attempt to fit into his civilian situation and is consciously aware of his symptoms, is preoccupied with his traumatic experiences in the Army, has recurring disturbing dreams, the chances are that he should see a psychiatrist. Just what the treatment would be is hardly within the province of this presentation. In the Army, we have found that psychotherapy under sedation is a valuable short-cut to relieve the pent-up emotion. Hypnosis has also proven to be an effective therapeutic tool for this purpose. In both of these types of treatment, the ultimate success depends upon the skill and the knowledge of the psychotherapist.

On the other hand, if the patient is exhibiting minor evidences of anxiety in the form of restlessness, minor physical complaints or problems of adjustment to the people around him, it is very likely that the general practitioner can and should help meet these problems. In so doing, he needs to appreciate that sometimes he can help directly by merely being a good listener and pointing out the inconsistencies, the discrepancies in the man's thinking and feeling processes. Very often he can make positive suggestions with regard to the manipulation of the environment. If one could insure sufficient family affection, economic and social security, easily accessible ego gratifications and good physical health, many of these veterans would be helped if not entirely rehabilitated.

When one takes into consideration the fact that 315,000 soldiers have been discharged from the Army for neuropsychiatric reasons, he may grasp the importance of this problem as a post-war challenge to medicine. A fair percentage of these have had combat experience and will present the dynamics and the clinical picture described in this presentation. It is to be hoped that all physicians will prepare themselves to accept and to treat what the Army medical officers discovered were among their biggest problems—the emotional factors in the production of illness.

BOOK NOTICES

Textbook of Abnormal Psychology. 3rd edition. By ROY M. DORCUS and G. WILSON SHAFFER. Price $4.00. Pp. 547. Baltimore, Williams & Wilkins Co., 1945.

To this book both Knight Dunlap and Ross Chapman write one-page forewords. In the one written by Doctor Dunlap he says that he is impressed with the vast amount of materials collected in this volume. So was this reviewer. Psychology, neurology, abnormal psychology, psychiatric diagnoses, and psychiatric therapy are all presented. But in nine pages of authors' index, the authors manage to exclude the names of most of the psychiatrists and psychologists with whom the reviewer is best acquainted, including Drs. Knight, Rapaport, Gill, Zilboorg, Kubie, Ebaugh, Sullivan, and others. My distant relative Menninger von Lerchenthal is, however, quoted, and Freud is cited twenty-six times, Knight Dunlap notwithstanding. (K. A. M.)

Psychoanalytic Therapy: Principles and Application. By FRANZ ALEXANDER, THOMAS M. FRENCH and staff members of the Institute for Psychoanalysis, Chicago. Price $5.00. Pp. 353. New York, Ronald Press Co., 1946.

The authors here present the results of their work over the past few years in attempting to apply psychoanalytic principles to what has previously been regarded as non-psychoanalytic psychotherapy. Their insistence that there is "no difference" between this and psychoanalysis is not convincing, nor is it substantiated. The discussion of some of the principles of psychoanalysis is excellent though incomplete; the case histories are of variable interest and clarity, but on the whole instructive and well presented. Just what they prove is not so clear. (K. A. M.)

People in Quandaries: The Semantics of Personal Adjustment. By WENDELL JOHNSON. Price $3.00. Pp. 532. New York, Harper & Brothers, 1946.

Wendell Johnson has a real gift for clear exposition of a subject, General Semantics, which is either obscure or over-popularized in the hands of other writers. He has written a vitally important book, illuminated with exquisitely appropriate anecdotes and examples, making it very readable. The section on Major Maladjustments is not up to the rest of the book, but the chapter on stuttering, entitled "The Indians Have No Word For It", is an original contribution to the obscure psychiatric problem of speech disorders. All workers in the field of psychiatry will find reading this book a stimulating experience. (R. P. K.)

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